POLICY ANALYSIS EXERCISE (PAE):

DEVELOPING A STRATEGIC PREVENTION FRAMEWORK FOR THE DOÑA ANA COUNTY HEALTH & HUMAN SERVICES DEPARTMENT

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EXECUTIVE SUMMARY

Doña Ana County, New Mexico is facing an enormous challenge and an equally enormous opportunity.

The challenge is that its public health and healthcare systems will be strained to the breaking point as the county's population grows, the costs of providing care rise, and funding from the state and federal governments remains unpredictable at best.

The opportunity is that the county has the capacity to meet these challenges and even get ahead of them. To do this, it must find new ways of lowering healthcare costs. Given that many of the most costly conditions are preventable (e.g., diabetes, teen pregnancy, etc.), increasing the number of successful prevention efforts would be a powerful strategy to achieve that end. However, because the county must continue to meet its legal and moral obligations for current care, new prevention efforts must be as effective and efficient as possible.

Although Doña Ana County is not a wealthy one, it has many assets at hand, including significant public health infrastructure, a large number of people and institutions committed to healthcare and public health, successful non-profits and educational institutions, capable management, and an energetic and committed political leadership, to name just a few. The question is how to get these pieces to work together. Toward that end, there are four steps the county's Health and Human Services Department should consider:

1. *Expand the use of partnerships and improve coordination*
2. *Develop new monitoring, measurement, and feedback strategies*
3. *Create a "brand identity" for prevention efforts in the county*
4. *Institutionalize these efforts with a Board Of County Commissioners resolution*

First, the Department should work to create more formal partnerships and to increase coordination and information-sharing. Partnerships are widely recognized as a cornerstone of public health efforts, and coordination helps to spread knowledge and innovations while reducing gaps and redundancies. Second, the Department must improve monitoring and measurement at the programmatic level to ensure resources are going to the most effective and efficient programs, and at the community level to ensure that the community knows what progress has been made and where work is still needed. Third, following the success of the C*olonias Initiative* in helping to generate interest and bring in outside resources, the Department should seek to create a "brand identity" around prevention. This will draw more attention to these efforts and help to bring in new potential stakeholders and partners. Finally, in order to institutionalize prevention as an official priority of the county, a resolution for the Board Of County Commissioners should be developed to capture the main points about the importance of prevention and the county's commitment to it.

BACKGROUND & SCOPE OF THE PROBLEM

The leadership of Doña Ana County is facing an enormous challenge. New Mexico law mandates that county governments are responsible for the "ambulance transportation or the hospital care or the provision of healthcare to indigent patients domiciled in that county."[1] With a population of nearly 200,000 spread out over an area the size of Rhode Island and Delaware put together, the county is struggling to meet its current healthcare obligations, and the gap between the services it supports and the needs of its residents threatens to widen.

The county is not a wealthy one. The mean per capita income in 1999 was $13,999, compared to $17,261 for New Mexico, and $21,587 for the whole US. One quarter of the population lives below the poverty line, compared to 18.4% for New Mexico, and 12.4% for the whole US.[2] Although new housing is being built at rapid pace in Doña Ana County, most of the new construction is unaffordable to the median income household.

In terms of race and ethnicity, the county is 63.4% Hispanic, and 54.4% of the population lives in households where a language other than English is the primary language spoken.[3] In short, the county is strongly bicultural and bilingual.

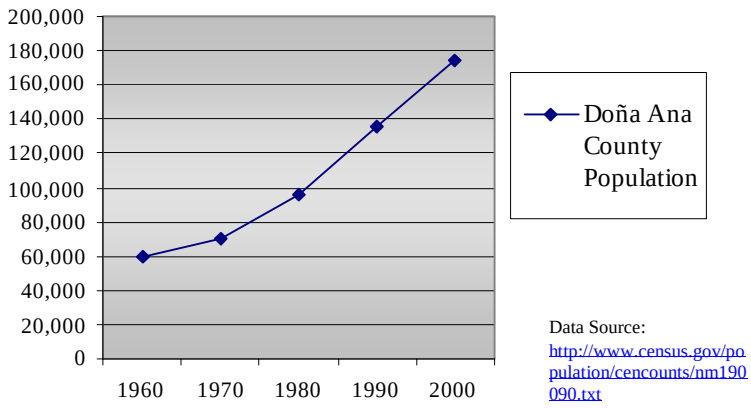
Additionally, Doña Ana County's status as a border county cannot be ignored when considering the health status of the population, because all communities along the US-Mexico border are "economically and socially interdependent" with their counterparts on the other side.[4] The constant flux of people across the border, both legally and illegally, has significant

implications that must be considered for all county policy. Doña Ana County also contains 37 of New Mexico's 141 federally designated *colonias*, which are low-income communities located near the US-Mexico border generally lacking infrastructure and containing a large proportion of immigrants (although different federal government departments use slightly different technical definitions).

The county's relationship with the centers of official political power is complicated. Although the county seat, Las Cruces, is by far the largest city in southern New Mexico with almost 80,000 people, it is dwarfed by nearby El Paso (over 500,000), which is itself dwarfed by its Mexican counterpart on the other side of the Rio Grande, Ciudad Juarez (over 1.1 million). The attention of the state government in Santa Fe tends to focus on the Albuquerque-Santa Fe region, while the focus of Texas state government is far from El Paso.

In terms of population growth, the county has been growing rapidly for decades. (Please see Chart 1 for long-term growth.) It grew by 28.9% between 1990 and 2000, and by another 6.5% between 2000 and 2004.[5] Given its housing boom and numerous publications naming Las Cruces a "best place to retire,"[6] it is likely to face continued rapid growth for the foreseeable future.

Chart 1: Doña Ana County Population Growth, 1960 - 2000



Data Source: http://www.census.gov/population/cencounts/nm190090.txt

While it is a significant challenge to estimate the likely changes in county tax receipts as a result of the rapid population changes—to say nothing of revenue estimates from state and federal funds—the likelihood of rising county healthcare costs is much greater than the likelihood of steadily rising revenue. Just in the last few months, potential cuts to two federal programs that provide the county with revenue (i.e., the Community Development Block Grants (CDBG) program and the Payment In Lieu of Taxes (PILOT) program for federally-owned land in the county) have been announced. Moreover, nationwide the number of physicians providing charity care has dropped by eight percentage points over the last decade.[7] If this trend is mirrored in Doña Ana County, it will put further strain on healthcare resources.

Putting all these pieces together, the county's healthcare challenge is enormous, and sufficient help is unlikely to arrive from either the state or federal governments. The county must continue exploring home-grown solutions. Since many of the most costly conditions facing the county are preventable, there are opportunities for significant long-run savings and far better health outcomes. In particular, diabetes, heart disease, oral health problems, teen pregnancy, driving while intoxicated, and some forms of cancer are all examples of conditions draining significant resources from the county that could be prevented. For example, there were over 11,000 adults in the county with diabetes in 2003.[8] For teen pregnancy, there were 48.5 births per 1,000 women between the ages of 15-17 in the county in 2000.[9] Both of these rates are higher than the rates for the state as a whole, and this is true for other costly conditions as well.

County health and human service departments are a relatively new phenomenon in New Mexico. In 2001, Doña Ana County's elected Board of County Commissioners (hereafter "BOCC") decided to fold together several health-related departments (e.g., Indigent Care, DWI, South Central New Mexico Prevention Coalition, etc.) into a comprehensive Health & Human

Services Department (hereafter "Department") for the first time. Currently, that department's mission is "to improve the quality of life of Doña Ana County residents by identifying and addressing unmet health and human services needs."[10] The Department's mandate thus extends beyond indigent care to all health and human services issues affecting the county.

Recognizing that the unified Department would benefit from a unified advisory body, in 2004 the BOCC and the Department worked to integrate several health-related councils and coalitions (made up of citizens representing a wide range of groups, interests, and geographic regions of the county) into a comprehensive Health & Human Services Alliance (hereafter "Alliance"), which was given an official role as an advisory body to the Department and the BOCC. Containing representatives of many important community constituencies and healthcare organizations, the Alliance is now finding its footing and beginning to shape its role. In the summer of 2005, the Alliance and the Department put on the first of a series of forums titled, "Juntos por Cambio: The Future of Healthcare in Doña Ana County," (hereafter the "*Juntos* forums") in order to listen to the healthcare concerns of community, to bring key healthcare stakeholders to the table to work together on common issues, and to begin to develop priorities and action items for a strategic action plan for the Department and the Alliance. The last of these forums, which focused on oral health, was held on January 21, 2006. The Department has now contracted with a researcher to pull the findings together for a healthcare initiative that the Department can undertake.

Parallel to that, many other relevant activities have started in the past two years. The Access to Care Committee—a standing committee of the Alliance that is a coalition of healthcare providers and several other key stakeholders—recently won a large grant to develop a county-wide medical information system that will allow providers to determine in a quick and consistent

manner what sources of assistance patients are eligible to receive. At the moment, each provider uses its own (often paper-based) system for determining eligibility, leading to significant redundancy, inefficiency, and errors in billing.

Additionally, at the first *Juntos* forum in July 2005, a community member suggested that a county healthcare ombudsman would be a useful resource. In response to this suggestion, the Department developed and implemented a county healthcare information hotline that began operation in February. There is also a new community nurses initiative, a growing number of community resource centers spread throughout the county, a strong *promotora* (i.e., community health worker) program, a network of AmeriCorps VISTAs working with the Department in the communities, a county *Colonias Initiative*, and an enormous number of other activities taking place. (For a partial list of relevant organizations and institutions, please see Appendix A.)

In short, this is a time of tremendous activity in Doña Ana County related to health and healthcare. The political leadership of the county, the management of the county, and key stakeholders are all energetically pushing ahead on numerous fronts.

PURPOSE OF THE PROJECT

The primary question driving this project is: How can the Department plan strategically in order to maximize prevention efforts in the county? Put in more concrete terms, the goal is construct a long-term strategic plan for increasing prevention efforts that the Department can implement.

Although definitions of prevention can vary significantly in scope, for the purposes of this report, the term is intended to be as inclusive as possible—including all forms of primary prevention, secondary prevention, health education, health promotion, etc., and dealing with all types of chronic disease, teen pregnancy, injury, abuse, etc.

It is critical to reemphasize that the problem is *not* there are few efforts at prevention going on in Doña Ana County at the moment. In fact, the problem is closer to the opposite. There are many efforts going on in the county, but they are occurring haphazardly. Just to cite one extreme recent example of this problem, late on the morning of January 18, 2006, two groups (the Teen Collaborative and the New Mexico Teen Pregnancy Coalition) were meeting simultaneously in Las Cruces to address the issue of teen pregnancy. At the beginning of the meetings, neither group was aware of the other's meeting.

In one sense, the purpose of this strategic plan is to fix this problem by finding ways to align all the disparate efforts going on, and to help the county become a clearinghouse of prevention efforts in the county. In this way, the Department can ensure that the prevention efforts as efficient and effective as possible. Beyond this, planning and coordinating prevention efforts will help ensure their continuity in the face of uncertain funding streams and changing political whims at other levels of government.

As a longer-timer goal, intermediate steps toward collaboration can hopefully provide the basis for galvanizing the community into a larger movement toward even more sweeping goals for improving the community's health.

Finally, it is important to note what is ***not*** included in the purpose of this project. First, this plan makes no attempt to establish priority areas for prevention efforts in the county. Those must be set, and to some extent are already being set, by the community itself through the Healthy Gente objectives (please see Recommendation 2 for further description), the *Juntos* forums, and general dialogue in the county. These priorities will be laid out more clearly in the report about the *Juntos* forums being prepared concurrent to this report. Second, this report makes no specific suggestions about how the prevention efforts themselves should look. That is beyond the scope of this plan and must be left to local experts and community members to decide.

ETHICAL CONSIDERATIONS

Before proceeding to the plan itself, it is important to address the ethical implications of funding prevention. The assumption behind this paper is that the community values prevention, but the situation is actually more complicated than that. As several key healthcare stakeholders noted in interviews, there is a potential ethical dilemma inherent in this project. Quite simply, if there are already insufficient resources to pay for current critical healthcare needs of the population, then it could be argued that diverting any healthcare funding to prevention violates both the Department's mandate and the implicit moral commitment to provide healthcare to residents unable to afford it. While this is a concern that must be taken very seriously, there are several responses. First, above all else, this plan will be seeking to find free or low-cost ways of achieving its ends. There is plenty of room both to improve the utilization of existing resources and to leverage them to bring in more outside resources. In this way, this project seeks to achieve as much as possible without diverting resources from current critical care needs.

Second, from a historical perspective, the Department's initial creation as a merger between several departments whose primary missions were related to prevention (e.g., Community Outreach, DWI, etc.) strengthens the case for the Department maintaining a key role in prevention efforts.

Third, there is a case to be made that the future critical care needs of the county are at risk if no action is taken. In this sense, there is an inevitable tradeoff between today's critical care needs and tomorrow's, with the obvious difference being today's needs are known, while tomorrow's needs (as well as the success rate of efforts to reduce them) are not. Nevertheless, all public policy decisions involve inter-temporal choices. While it is difficult to measure the net present value of saving and prolonging lives now versus preserving that ability for the future, it

is unlikely that any policymaker would entirely forgo investment in the latter. Empirically, the fact that any government whose mandate includes providing healthcare to the indigent also spends money on infrastructure improvement (which describes Doña Ana County) supports this conclusion.

METHODOLOGY & RESEARCH

Three different types of research were conducted for this project. First, interviews were conducted with both stakeholders in the county and experts in a variety of fields (e.g., public health, communications, health technology). Second, a rudimentary content analysis of county health department strategic plans was performed. These were examined for common themes, topics, and strategies, as well as innovative ideas or potential best practices. Third, an extensive literature review was conducted. This included searches for best practices of local efforts to galvanize a community around prevention specifically or around some health issue more generally, best practices for partnership-building and multi-agency collaboration, and the academic literature on these and related issues. A description of interviews conducted and a list of strategic plans reviewed appear in Appendix G, along with a bibliography.

Throughout this process, numerous potential policy changes surfaced and were considered. Those that were not included were rejected for a variety of reasons. Some were rejected because they were not feasible given the personnel resources available (e.g., developing a large micro-grant program would require too much staff time for the potential benefits); some were rejected because they were considered too close to existing programs and services (e.g., designing a web-based system for prevention activity reporting); and some were rejected because they were beyond the scope of this project (e.g., suggesting public health policies to target specific diseases, or proposing the county implement an internal workplace wellness program).

In the end, the recommendations that follow were selected because they are politically and economically feasible opportunities to improve the county's prevention efforts over the long run, because they are supported by research, and because together they make a coherent plan of action that can be implemented.

RECOMMENDATIONS & ANALYSIS

As noted, both the lack of resources and the ethical considerations about policy tradeoffs between current care and prevention mean that county efforts must begin with low-cost and no-cost options. Fortunately, there is plenty of "low hanging fruit" available. Underlying the following specific recommendations is the idea that the Department specifically and the county more generally have assets that they may not been deploying as fully as possible.

In terms of specific proposals, there are four inter-related policy recommendations that the Health & Human Services Department should consider implementing:

- Expand the use of partnerships and improve coordination
- Develop new monitoring, measurement, and feedback strategies
- Create a "brand identity" for prevention efforts in the county
- Institutionalize these efforts with a Board Of County Commissioners resolution

RECOMMENDATION 1: EXPAND THE USE OF PARTNERSHIPS AND IMPROVE COORDINATION

Partnerships often provide an efficient and effective way for government entities to create public value and are being used with increasing frequency at all levels government.[11] As local public health departments have grown in number and scope of work, partnerships have become a cornerstone of local public health and healthcare efforts.[12] Numerous national organizations devoted to local public health and prevention make partnerships central to their strategies. The National Association of City and County Health Officials (NACCHO) focuses on partnerships with its Mobilizing for Action through Planning and Partnerships (MAPP), which NACCHO describes as "a community-wide strategic planning tool for improving community health."[13] Additionally, the Centers for Disease Control and Prevention's Planned Approach to Community

Health (PATCH) model,[14] the Work Group on Health Promotion and Community Development's Community Tool Box[15] and the National Association of Counties' (NACo) Return On Community Investment (ROCI) guidelines[16] all give a central role to partnerships.

Moreover, nearly all of the strategic plans examined acknowledged the essential role partnerships and collaborations must play in prevention efforts, and nearly all made reference to their own usage of partnerships. The strategic plan of the Wood County Combined General Health District (OH) notes that "[t]he health district has a history of working collaboratively with our numerous community partners and organizations to develop ways to solve problems in the most cost effective manner possible."[17] The strategic plan of the Multnomah County (OR) public health department includes as a goal: "Create and enhance partnerships and collaborations to increase community capacity, leadership, and responsibility to promote health."[18] Finally, according to Seattle & King County's (WA) public health department strategic plan, 31% of the Public Department's funds in 1999 were "allocated for the provision of contracted services through community providers and partners."[19]

The academic literature on local partnerships with regard to public health is extensive.[20] If properly structured and managed, they can make valuable contributions to improving population health[21] and related health policies.[22] However, partnerships also involve many challenges.[23] The question is how to create structures that increase the chances of success.

Looking at the literature on what increases the likelihood of a successful partnership, several important points stand out. First, the partnership needs to make sure that it has a mission that will be able to create and sustain public value. It must be able to do this while also creating value for the non-governmental partners involved (whether that value involves fulfilling their own missions to serve the public, satisfying the needs of their leadership and donors, or simply

turning a profit). In other words, the partnership must have "goal congruence."[24] Second, all partners in the partnership need to be able to trust each other and trust in the continuity of their dedication and contribution to the partnership.[25] This trust must include the willingness to share risk.[26] This can be especially difficult when there are a large number of partners with differing levels of involvement. Third, each partner involved must bring a "core competency" that fits with the mission, values, and strategy of the partnership. That is, the partners involved must have a balance of "resources, expertise, political connections, and past experience" to ensure that there is "complementarity."[27] This collection of differing resources is partially what motives the creation of the partnership in the first place.

Turning to external issues, the partnership's mission needs to be clear to outsiders. In the context of public health in particular, it is critical to "frame and communicate a clear vision and mission that is broadly understood (not just by health-related professionals). The mission should define the problem and acceptable solutions in such a manner as to engage (not blame) those community members most affected."[28] Care must be taken to ensure that the work and progress of the partnership toward its mission is being measured, so that partners and the community at large continue to see that value is being generated. The partnership should make sure that its work is being noticed by the community through "communications, resource allocation, recognition and celebrations, and systems of rewards and accountability," and should make sure to include in its mission goals that address "issues that matter to people over time…across concerns…and across generations of dispersed leadership."[29]

The actual governance structure of the partnership also needs to be considered carefully, since what might otherwise be a very effective program or service could easily be derailed by disagreements over minor governance issues. The type of partnership governance structure that

works for one partnership may not necessarily work for another. To deal with this, it is critical to establish clearly early on how the partnership will be governed.[30]

Finally, a successful partnership must have effective leadership. Although this is probably the most difficult characteristic to try to develop deliberately, among all the studies reviewed in one large-scale review of the literature, it was "the most often reported internal (or organizational) factor for a partnership's effectiveness in creating community and systems change."[31]

Within Doña Ana County itself, partnerships are already in significant use, and there is interest in more partnerships from the county perspective, from the state perspective, and from local non-profit organizations. When it comes to prevention, the county currently contracts with over almost a dozen different clinics (e.g., First Step Center), non-profit organizations (e.g., La Piñon), hospitals (e.g., Memorial Medical Center), and other governmental entities (e.g., State Department of Health's Public Health Division) for programs and services. Of course, true partnerships are more than a simple contract for services. They are more enduring and generally involve shared interests beyond a simple financial contract.[32] There are many examples of existing partnerships around health and healthcare issues in Doña Ana County. (Please see Appendix A for examples.) Two in particular will be critical as the size and complexity of the county's public health challenges and infrastructure increase: the Alliance and the Access to Care Committee (see Background for descriptions). These two partnerships can serve as examples for future partnership-building in the county. Additionally, the Alliance could become a key player in the building of future partnerships.

The Alliance is the natural hub for improving and expanding partnership activity for three reasons. First, the BOCC resolution that created the Alliance included in its mandate the

responsibility to "serve as the primary advisory body to the Department and support the improvement of health and human services status for all populations," to "work to synchronize efforts among the existing public health and healthcare systems through community advocacy, education, and resource development," and to "support the development and sustainability of a fundamental Departmental and community framework that encourages the improvement of public health and healthcare systems in the county."[33] Second, its diverse membership "includes representation of key public, private, voluntary, and not-for-profit stakeholders and community-based representation that ensures fairness, geographic and demographic balance."[34] Third, like the Department, it was initially created as an amalgam of issue-specific entities (i.e., the Health Council, DWI Advisory Council, and the Maternal & Child Health Council). For these reasons, the Department should encourage and assist the Alliance to evolve into a catalyst and incubator for further partnerships in the county. How might it do this?

As a first step, the Department should encourage the Alliance to consider making a minor internal structural change to improve the process of selecting new members. Under the current system when a member leaves the Alliance either by resignation or by removal (which usually occurs after a member misses the maximum number of meetings allowed without sending an alternate), applications are sought for the new position. In an attempt to maintain a balance of constituencies, potential applications for the new position must share some of the organizational or demographic characteristics of the member who left. This is understandable from the need to preserve diverse voices on the Alliance, but it has also blocked some potentially valuable members from joining. Several key constituencies and organizations remain unrepresented. Moreover, the Alliance's mechanism for actually voting on applications is secret ballot, a method that does not seem appropriate for a body initially officially created by the BOCC as the

"primary advisory body to the Department."[35] To ensure the continuation of a broad membership that includes all critical stakeholders and to improve transparency, the Department should encourage the Alliance to consider making voting for new members an open ballot process.

Once the results from the *Juntos* forums are fully developed into a set of priorities for the healthcare initiative and the Alliance has finished the other immediate tasks on its plate, the Alliance may want to consider working with the Department and the county's Public Information Office to develop a media strategy and take steps to raise its profile in the community. This is important for several reasons. By raising its profile, the Alliance will be able to attract more interest not only to itself, but to the other partnerships that are connected to it. Second, as noted, one factor in the likelihood of partnership success is the partnership's ability to communicate what it is doing to the public. This is especially important since there is evidence that local media coverage can sometimes focus on "decision-making processes of community partnerships, and not the more tangible activities of the many community improvement projects" that the partnerships develop.[36] For the Alliance to be able to keep the focus on the actual projects it undertakes, it will be important to have a plan that helps it avoid coverage focusing on process rather than content. Finally, linking the Alliance with the county's Public Information Office could help Alliance think about new ways of improving their own internal communications strategies while helping the Public Information Office gain a new perspective on some of the complicated health issues that need to be explained to the media.

Beyond these internal changes for the Alliance, there are several steps the Department and the Alliance can take together to put the Alliance in a position to assist existing partnerships

and to spin off new partnerships as priorities and issues are identified for the healthcare initiative and for future challenges that arise.

First, the Department should encourage the Alliance to capitalize on all its assets (e.g., its prestige and advisory role to the Department) as incentives to bring people and organizations to the table. This already happens to some degree because so many Alliance members also work for and represent key organizations in the county. One way it might do this more formally would be create a process by which the Alliance could vote to offer an official "endorsement" of other partnerships based on a predetermined set of criteria. These partnerships could then report back on their work and progress to the Alliance itself, as the Access to Care Committee now does.

Even more concretely, there are some limited financial resources that may become available for these efforts either from a non-profit interested in partnering with the Department or from county funds themselves. If this money becomes available, it could be used as seed money to incentivize the creation or strengthening of sustainable partnerships focused on the priority issues identified. In addition to meeting a predetermined set of criteria based on the strategies for successful partnerships laid out, partnerships applying for seed money would have demonstrate that they had a feasible plan for raising their own revenue (e.g., through grants, contributions, etc.) after the seed money was used. If the money comes from the county, then the process of integrating it with the new Request For Proposal (RFP) process just introduced is a question that would have to be examined after that process has been completed once and formally evaluated. (For a further discussion of this process, please see Recommendation 2.)

In addition to the key organizational and institutional stakeholders who should be involved in any partnerships, the Department and the Alliance must continue to ensure that communities throughout the county are represented in any new partnerships. This is especially

true in the case of the Community Health Coalitions (CHCs), which are groups of residents of local communities (including many in the *colonias*) devoted to improving the health of their neighborhoods, and in the case of the *promotoras*, who are health education and outreach workers located in many local communities. The involvement of both CHCs and *promotoras* will be critical to the success of developing programs that are culturally appropriate in local communities, regardless of the particular issue being addressed.

The Department and the Alliance should also consider looking beyond the usual suspects in trying to expand existing partnerships and nurture new ones. There is no reason why grocery store managers, law enforcement agencies, teen peer advocacy groups, or other groups not always considered central to health issues cannot be more deeply involved—as long as they meet the above criteria (e.g., trusty-worthy, provide some useful core competency, etc.). Sustainable long-term change is more likely when "leaders emerge from and engage multiple community sectors in facilitating change within their own peer group, organizations, and context."[37]

How might all of these steps look in practice? One example of an existing prevention-related coalition that the Alliance and the Department could work to nurture is the Diabetes Action Coalition. Although this Coalition has been around for several years, in the last year it has stepped up activities around its mission of increasing diabetes prevention. This Coalition already has a list-serv of about 50 people and contains members of some of the many diabetes-related organizations and institutions in Doña Ana County. At present there are no overlapping members between the Diabetes Action Coalition and the Alliance. To begin, the Alliance and the Department could invite the Coalition for a joint meeting to inform the members of each partnership about the other, build bridges between the two groups, and begin looking specifically for simple ways that each group might contribute to the other's work. From there, assuming it

met the formal set of criteria the Alliance had put in place, the Alliance could consider offering an official endorsement of the Coalition's work.

Beyond the Alliance's value as an example and incubator of partnerships, the Access to Care Committee can serve as a second model partnership in the county. Its success in obtaining a grant for a county-wide project that will benefit many constituencies demonstrates the value that such partnerships can generate in Doña Ana County. This is key in creating new partnerships, since "[o]ne of the best ways to sell a new initiative to partners, to funders, to community leaders, is to share a success story, a program that you can use as a model."[38]

Moreover, if its successes continue, the Access to Care Committee will demonstrate the feasibility of county-wide technological innovations, which would be valuable in encouraging groups to form partnerships around potentially more innovative approaches to prevention. Several county health department strategic plans reviewed (e.g., Seattle & King County, and Buncombe County Public Health Foundation) noted the difficulties in the usual approaches to public health work and the importance of looking for new and innovative ways to increase prevention efforts. This is especially important given that many media channels used commonly for public health projects are already deluged with issues competing for space on the agenda.[39] There is good evidence supporting the notion that government can effect behavioral change with methods outside of traditional prevention models (e.g., tax incentives, zoning restrictions, etc.).[40]

Partnerships should not be and could not be the only method for increasing prevention efforts. In some cases, entities will continue working on their own on projects, programs, and services, and in other cases less than formal or short-term collaboration may be preferred over the time-consuming process of developing formal partnerships. For this reason, informal coordination and collaboration of the wide array of prevention initiatives pursued independently

must be improved in order to minimize potential gaps, redundancies, and inefficiencies that might otherwise go unnoticed, as well as to ensure that ideas and innovations diffuse effectively across organizations. "Knowledge sharing typically does not typically just happen. It requires building an infrastructure and set of routes that promote the transfer of knowledge within the network."[41] In this sense, the Alliance can, and in fact already does, act as the "water-cooler"—the type of informal information channel that is often weakened in a networked approach.[42]

Several strategic plans explicitly noted the importance of coordination. For example, the strategic plan of Broward County's (FL) notes that "[s]trengthening communication and planning among differently funded programs and organization 'silos' is critical, especially to those that serve or target the same populations."[43] The Seattle & King County plan states that the department should "[i]ntegrate departmental and cross-departmental programs and services to leverage resources and achieve efficiencies" and "[c]ontinuously examine cross-departmental, divisional, and regional opportunities to share information, resources, and people."[44]

Perhaps most abstractly, the Alliance and the Department have a role to serve as vehicle for building trust, which is "the bedrock of collaboration"[45] and contributes to increasing a community or group's social capital.[46] Given some of the bad blood that has built up over the years between organizations in the county, the Alliance by its very existence has implicitly played a role in building trust between organizations. It may be an opportune time for the Department and the Alliance to explore ways of taking an even more explicit role. (For an elaboration of one possible way to do this, please see Recommendation 3.)

Of course, strengthening partnerships and improving coordination between efforts may be valuable, but without a plan to monitor, measure, and give feedback for those efforts, there is no way to know what kind of value they are providing.

RECOMMENDATION 2: DEVELOP NEW MONITORING, MEASUREMENT, AND FEEDBACK STRATEGIES

The importance of accountability in all these efforts cannot be overstated, whether the prevention efforts are performed directly by the Department or by partnerships, since the Department cannot use partnerships to evade responsibility for the quality of the programs and services it provides.[47]

Almost all of the strategic plans examined noted the importance of monitoring, measurement, benchmarks, and outcomes. The strategic plan of the Benton County (OR) public health department lists as its first initiative: "Public Health Information Management: Strengthen Community Health data gathering, management & evaluation."[48] The Broward plan lays out a rigorous procedure for monitoring and measurement: "At least quarterly, each program's performance data is formally reviewed by the Lead Section and presented to the BCHD Quality Management Team…The data presented includes results of process measures, the services that were provided and resources applied to each program." Despite these examples, due to the significant costs of high-quality monitoring and measurement efforts, "[f]ew local health departments and even fewer local collaborative partnerships can regularly and systematically collect behavioral measurements of their target populations, either with behavioral surveys or observational methods."[49]

Accountability is critical at two levels: the level of the program or organization, and the level of the community at large.

First, looking at the programmatic or organizational level, there are several challenges to developing a concise set of metrics for a plan focusing on prevention. Even some of the most widely used prevention programs in the nation have difficulty demonstrating effectiveness. For example, of the six major studies that the GAO reviewed of the popular Drug Abuse Resistance

Education (DARE) program, which has been used across the nation for many years, none was able to demonstrate a statistically significant effect.[50] The main categories of measurement pose significant problems for program-level monitoring. Due to the time lags involved and the challenges of establishing causality, measuring outcomes is not generally feasible for annual program selection and budget-setting, since outcomes are "often murky, hard to define, and harder to measure—and may take many years to realize."[51] Measuring inputs is more practical, but it unfortunately does not tell a lot about the success of programs or the value generated.

Additionally, prevention efforts can have positive spillover effects that are difficult to capture in traditional cost-benefit analyses. For example, research has shown that an effective drug prevention program in middle school can reduce later risky driving in high school.[52] Some have also argued that traditional studies of costs and benefits of prevention efforts are inadequate because they only capture changes that occur during the (often limited) timeframe of the study, and that they do not capture movements in subjects "stage of change."[53] Finally, partnerships provide an extra layer of difficulty in improving accountability, since "the very complexity that necessitates a networked solution often makes the accountability process quite difficult."[54]

The challenge is to implement a system that grapples with these problems while allowing for comparisons across efforts and over time. The convenience and simplicity of the system will also be critical, because the people most likely to be in charge of reporting are already burdened by numerous requirements and mandates.

The Department is already taking steps to improve the coordination and monitoring of its external contracts. Over the past three years, the Department has included more formal and sophisticated reporting requirements. There is now a standardized format contractors must use to report the services performed on a regular basis. These reports are used in comparison to the

Scope of Work laid out in the initial contracts. Contractors for services can now email their reports to the Department.

As noted, the county has moved toward joint RFPs for all organizations that seek to contract with the Department for different categories of services (e.g., Primary Care, Behavioral Health, and Emergency Medical Transport). This year is the first year that this new process is being used, so there is not yet a way to evaluate its impact, but it is hoped that this new RFP process will spur greater cooperation between organizations and lessen any gaps or redundancies. Taken together, these two pieces have led to wealth of data available for analysis. How might the Department capitalize on these improvements and develop the system even further, especially with regard to analyzing the data received?

Although there are numerous ready-made frameworks and templates available for developing further program evaluation, the Department simply does not have the personnel to perform a thorough evaluation of all programs, especially if there is a significant increase in the number of prevention programs. This is another opportunity where engaging community partners could have a significant positive impact. There are several potential partners whose core competency would include program evaluation that should be more directly engaged in the process.

In particular, NMSU presents the Department with another opportunity to deploy an asset that it has not utilized as much as it could: prestige. Offering students in NMSU's Department of Health Science, Government Department, and the College of Business Administration and Economics opportunities to gain practical program evaluation experience through an internship or practicum with the county is a way to provide benefits to both the Department (i.e., additional personnel resources) and the students (i.e., experience, prestige, and

references). Academic institution-local public health department partnerships have been used in numerous settings,[55] including in models similar to the one being proposed.[56] In particular, there are several documented strategies for structuring or improving public health internships in local health departments.[57] (Please see Table 1 for list of strategies.)

Using these to tailor an internship program between NMSU and the Department could increase the likelihood of this program's success—although some of these strategies are obviously outside the control of the Department and are purely internal matters for NMSU. Additionally, it may be possible to get technical assistance in setting up this evaluation program from the New Mexico Department of Health's Public Health Division district office, and the Border Epidemiology and Environmental Health Center within the Department of Health Sciences at New Mexico State University—although here again there may be issues of personnel availability. These organizations have experienced researchers who understand program evaluation and already have worked with the county on many programs and projects.

Table 1: Strategies for improving academic-local health department internships and practica[58]
• Improve the management of practica • Increase the number of funded internships • Require public health practice in MPH/DPH curriculum • Ensure that students identify learning objectives and require preceptors and academic advisors to endorse students' work plans • Establish a formal process whereby schools and health departments negotiate the time commitment required of the student, health department staff, and faculty advisor; the expected mentoring roles of faculty and health dept participants; and each institution's expectations concerning authorship of potential publications • Ensure that internships are tailored to meet real needs • Develop courses and workshops to introduce students to public health practice • Make available a pool of students and faculty to support health depts in the event of outbreaks or emergencies. • Encourage students to conduct community health assessments and work with community organizations

A second way to improve accountability at the program level would be to encourage future projects to utilize a common framework from the beginning. This would allow for comparison between proposals and make progress easier to monitor. While there are many

frameworks and templates available for planning public health projects, one that would be a good fit for future prevention projects in Doña Ana County is the Return On Community Investment (ROCI) model. As defined by the National Association of Counties (NACo), ROCI is a "method to measure and show community value in exchange for a given resource investment from public and private partners who undertake joint initiatives to improve access and reduce health disparities."[59] This model fits because it is straightforward, thorough, and designed for the county level. (Please see Table 2 for the steps of the ROCI model.)

In addition to the steps listed, one additional step that should be added to this model is "Institutionalize the plan," in order to increase the likelihood that programs would survive a change of organizational or county leadership. The continuity of programs dealing with issues still considered priorities should be assured as long as they remain effective and efficient at dealing with those problems, regardless of changes of leadership.

Table 2: NACo's Return On Community Investment Model[60]

The ROCI model contains three parts, broken down into seven steps:

- Part 1. Design an enterprise that produces outcomes partners will value
  - Step One: Find benchmark communities rather than reinvent the wheel
  - Step Two: Lay out the logic and measurement strategies at the start
- Part 2: Figure out the deals to make among state and community partners
  - Step Three: Make the Return On Investment (ROI) business case to potential investors
  - Step Four: Create community-wide view of value
  - Step Five: Create a community scorecard
- Part 3: Make the community context and how to change it to support the deal.
  - Step Six: Generate greater community readiness
  - Step Seven: Promise and deliver accountability.

Source: *Return On Community Investment: A Practical Primer for County Officials*

Turning to the community level, monitoring and measurement involve some different challenges, and it can be argued that "[g]ood oversight concentrates on outcomes, not processes."[61] Fortunately, there is already a set of objectives that can serve as a base set of outcomes for community-wide evaluation of progress. The Healthy People/Healthy Gente 2010

objectives are a set of objectives developed at the national level by the Healthy People Consortium, a group that includes members from over 350 national and state agencies and organizations.[62]

These objectives were intended to be tailored by states, local governments, and other organizations, and have been further elaborated by the US-Mexico Border Health Commission into the Healthy Border 2010 objectives.[63] From the county perspective, the objectives have been incorporated into official priorities by the BOCC resolution chartering the Alliance, which gives it the responsibility to "complement the Department's and other stakeholders' strategies in meeting related county, state, and national priorities such as Healthy People 2010, the New Mexico Comprehensive Strategic Plan, and Healthy Gente/Healthy Border 2010."[64]

The Border Epidemiology and Environmental Health Center has put together an actual Healthy Gente/Health Border 2010 scorecard for Doña Ana County in 2004. (Please see Appendix B.) The question is how the county can hold itself accountable for those goals. One potential solution is to take the existing report card and package it in a user-friendly way for distribution to the community and the media at regular intervals. The Arizona Department of Health Services has a user-friendly Healthy People 2010 report card that could serve as a template. (Please see Appendix C for a sample page from Healthy Arizona 2010 Report Card.) Disseminating a similar report card in Doña Ana County at regular intervals could help in creating a broader discussion among the community, as well as maintaining the incentives for the Department, the BOCC, and all partners and stakeholders to continue those programs that are working and make changes to those that are not.[65]

RECOMMENDATION 3: CREATE A BRAND IDENTITY FOR PREVENTION EFFORTS IN THE COUNTY

So far, all these steps are fairly unconnected and risk further exacerbating the very problem of coordination that they are intended to improve. What is needed is a way of linking all these pieces together.

The Seattle & King County strategic plan succinctly sums up the challenge for attempting to get the public, political leaders, and other key community stakeholders to focus on more prevention efforts: "Public health is essential, and it is a bargain; however, it is often invisible. People cannot see disease outbreaks, injuries, or early deaths that do not occur. In contrast to the medical care system, which helps one individual at a time, public health helps entire communities."[66] Creating a prevention brand could help to sustain the message of the importance of prevention even when the specific priorities or focuses change to meet new challenges (e.g., the rise of crystal meth use).

Another way to look at this possibility is in the context of health promotion agenda-setting—a relatively new concept for which pioneering research is being conducted at NMSU itself. This is the study of "how health promotion and public health policy agendas are set and influenced."[67] A brand identity could provide a stable context for stakeholders to work together for "a more effective pre-decision agenda."[68] This could improve media coverage of specific issues. Media coverage, in turn, can have self-reinforcing effects by getting the notice of state legislators and by increasing the community's interest in the efforts.[69]

In short, the "brand identity" should establish the idea that prevention of diabetes, teen pregnancy, injury, etc. should not be viewed simply as distinct efforts to deal with separate issues, but rather as part of an overarching plan to improve the overall health and wellness of all residents of Doña Ana County. If done properly, a prevention brand could establish a new

precedent that forces all future discussions of related policy issues to respond in some way to this new framework.[70] Organizations working on prevention-related issues should not see themselves in a zero-sum competition for resources and attention with organizations working on other issues. Instead, the Department needs to demonstrate to the key stakeholders and constituencies that all will be better off if they recognize that "[t]he capacity of the system is not constant from one time to another, nor is there a fully zero-sum competition for space on the agenda."[71] This is, of course, far easier said than done, because the pool of resources available at any given moment will always seem smaller than the resources immediately desired.

Any marketing effort for prevention will need to be broad enough that it does not put off any potential partners, but narrow enough that it does contain specific steps the Department can take. Putting together an entire framework is beyond the scope of this paper. However, it is possible to lay out the basic process and major pieces that ought to be included.

A social marketing plan development process typically follows eight basic steps: (1) Analyze the social marketing environment, (2) Select target audiences, (3) Set objectives and goals, (4) Understand the target audiences and the competition, (5) Determine strategies—The 4 Ps (product, price, place, and promotion), (6) Develop evaluation and monitoring strategy, (7) Establish budgets and find funding sources, (8) Complete an implementation plan.[72] Because this plan is different in several ways from a traditional social marketing plan, steps six and seven are not entirely applicable and will be left aside.

Looking at the social marketing environment for a potential campaign to build a prevention brand, it is helpful to start with a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis. The strengths for the proposed campaign include the large number of people and organizations already committed, the effects of the recent *Juntos* forums, and the fact that a

general healthcare initiative is being developed. The weaknesses include the need to minimize financial resources used, the existing turf issues, and the fact that staff are already overburdened. The most salient opportunities include the potential to link this plan to the general healthcare initiative, the county government's move to a new, centralized location, and the fact that there are non-financial assets available to the Department. The main threats would be dilution of message and the potential for new pressing health needs that may arise unexpectedly. (For a SWOT analysis for this proposal, please see Table 3.)

Table 3: SWOT Analysis for Creating Prevention/Wellness Brand Identity in Doña Ana County

Strengths	**Weaknesses**
• Large number of people and institutions already committed to public health, prevention, etc. • "Juntos Por Cambio" forums brought community together and generated list of priorities • Some political will for these efforts exists • General healthcare initiative being planned	• Must keep financial resources used to a bare minimum • Still some turf issues, and resources still seen as zero-sum • Existing organizations, managers, and staff already overburdened with work
Opportunities	**Threats**
• Can link this to forums and general healthcare initiative • County government's move into new building can be a fresh start • County underutilizing its non-financial assets	• Message dilution because of the larger healthcare initiative and the existing *Colonias Initiative* • Initiative could be overtaken by new pressing needs that develop

Having this broad view of the environment, the next step is to identify the target audiences for the campaign. While the overall long-term goal is to reach everyone in the county, this is obviously not remotely feasible, and even if it were feasible, it is unlikely to be an effective strategy.[73] Therefore, the real target audience of this campaign must be opinion leaders and the management of key organizations and institutions in the county (e.g., school administrators, business leaders, religious leaders, etc.). According to diffusion theory, "opinion leaders are especially communicative and accessible, are perceived as expert but also trustworthy, and act to preserve and strengthen the networks in which their advice is accorded

high regard.[74]" These people often not only are influential with decision-makers, but often their actions are copied by others. This is still a broad group, but it is narrow enough that an effective campaign could be tailored to it.

With the target audience identified, the next step is to identify explicitly the Objective of the campaign. In this case, the primary Objectives are: (1) To get these leaders to take steps within their organization or sphere of leadership to push the message that Doña Ana County, as a government and as a county more generally, is absolutely committed to prevention, (2) To get them to look for innovative, low-cost changes they can make in their own organizations, institutions, and neighborhoods, and (3) To get them to join partnerships connected to the efforts. As for Goals, it is difficult to say for this plan what number of new partnerships or innovations spurred would be an acceptable Goal at this point in the process, but within a year there should be clear progress toward new partnerships (and strengthened existing ones) around the priority issues identified.

The next step is to analyze more deeply the target audience and the "competition." On the surface it seems that one potential competitor is the *Colonias Initiative*, which the county began last year as a model effort to focus resources and attention on the challenges and issues of the Doña Ana County's 37 *colonias*. (Please see Appendix F for description of the initiative.) A new prevention effort must not threaten the momentum and successes generated so far by the *Colonias Initiative,* even as it uses the *Colonias Initiative* as a partial template. Fortunately, the two initiatives would actually complement each other, because health issues are extremely important in the *colonias*, and the *colonias* in turn have an enormous impact on the county's health resources. Moreover, the C*olonias Initiative* is working to build more physical infrastructure in the *colonias*, which is in many ways a precondition for allowing a greater focus

on health issues. The challenge is to emphasize that the *Colonias Initiative* and this new effort are not competitors but actually complement one another, while at the same time keeping the messages untangled and not overloading recipients with information or demands.

The other potential competition is more abstract than any organization or institution pushing an explicitly opposing message. It is simply the other items on the "to do" lists of the target audience, since the primary "cost" of the change we are seeking involves devoting time and energy toward a new priority, as well as what might best be described as "inertia." In this context, this inertia takes several forms. It describes the fact that people and organizations become comfortable with an old way of doing something and see little reason for changing long-held standard operating procedures.[75] Additionally, there is inertia embedded in the very turf issues that have developed over the years, although as previously noted this inertia has already started to loosen.

Having mapped out in broad terms the environment and the competition, it is time to lay out the framework of the "four Ps"—product, price, place, and promotion—of what a campaign might look like. Dividing the product into the "core product," the "actual product," and the "augmented product," the core product is the long-term benefits from a healthier community. The actual product for this campaign is more involvement in county efforts for more prevention, as well as more efforts to find innovative prevention ideas. To support this, the "augmented product" must make getting involved in the effort as convenient and rewarding as possible.

The "price" in a social marketing campaign like this—that is, "the cost that the target market associates with adopting the new behavior"[76]—is the time and financial resources that will need to be invested to make it work, plus any psychological discomfort from having to change old habits and long-held standard operating procedures.

The "place" is actually going to be rather diffuse in these efforts, since the goal is partially to have stakeholders help make prevention activities "extended to residents of…[the] county wherever they live, work, learn, or play,"[77] in the words of the Benton County (OR) health department's plan. Put another way, the goal is to make stakeholders realize that the "place" for more prevention is anywhere and everywhere they have any ability to make people healthier in the county.

For the "Promotion" of this effort, the message must be simple, direct, easily translatable, and culturally appropriate. It also must be flexible enough to include a variety of different sets of values. For example, encouraging prevention as a means toward a healthier community might be important for business leaders because of the cost savings for their companies, for school leaders because of the improved educational outcomes of their students, and for religious leaders because of the effects of health on families.

Bringing all these pieces together, there are three concrete steps that the Department can take to move this effort forward. First, the effort must have an official name that highlights its key aspects. A natural choice would be to capitalize on the *Juntos* forums by choosing a similar name. Keeping the "Juntos" would reinforce the idea of collaboration and cooperation underlying this entire effort, as well as the idea that the county includes both the city and the *colonias.* Since the long-run goal of the whole enterprise is to improve the health and wellness of the county, a possible name for the effort would be "Juntos Por Salud" (i.e., "Together for Health"). Not only does this name fit with the criteria laid out above, but it does not appear to have been used before in any similar capacity.[78]

Second, it is critical for any marketing effort to have a logo that will be "recognizable, familiar, [that will] elicit a consensually held meaning in the target market, and [that will] evoke

a positive affect" associated with it.[79] As with the name, the logo must highlight the campaign's key aspects, while being distinct from the C*olonias Initiative* logo. The Department could encourage all prevention-related activities in the county to affix the campaign's logo on their literature for individual efforts. However, the Department should develop a set of broad criteria for granting the right to use it and should request that organizations seek permission from the Department before using it. These criteria might simply include basic requirements like not promoting illegal or destructive actions. Requiring permission would serve two purposes. First, in the case of any potentially illegal, destructive, or controversial efforts, the Department could reserve the right to deny usage of the logo. Second, this would provide one more incentive for anyone engaging in a prevention-related effort to contact the Department, which would provide a further boost to coordination efforts. To obtain a logo without having to expend financial resources, the Department can once again use its ability to provide non-financial rewards by holding a design contest for students at Doña Ana Branch Community College (DABCC), NMSU, or the community at large.

Third, the Department and the Alliance should consider taking advantage of the fact that pioneering research in the relatively new field of health promotion agenda-setting is being done in Doña Ana County itself by several professors at NMSU. The Department should seek technical assistance in ensuring that a county prevention "brand" acts as a complement to the agenda-setting process.

Finally, as noted earlier in the example of creating fellowships for local college students and the logo contest, the Department has prestige that it can exchange for services and assistance. In the case of this larger campaign, the Department could consider creating an annual set of awards for individuals and organizations that have done the most to advance the cause of

prevention in Doña Ana County. The Department could even combine that with another of its assets—its "capacity to convene" as a governmental entity[80]—to create an annual awards banquet honoring the recipients of such awards. Given that "recognition and celebrations, and systems of awards and accountability" are often a factor in successful partnerships for community health,[81] there is no reason to think that they would not equally valuable to a community-wide initiative. Moreover, there are precedents in the community that demonstrate this idea's feasibility. The banquet that the Department holds to honor its AmericaCorp VISTAs and the *Juntos* forums both were very positive events that drew large number of stakeholders.

RECOMMENDATION 4: INSTITUTIONALIZE THESE EFFORTS WITH A BOCC RESOLUTION

Finally, part of the reason the *Colonias Initiative* was able to garner such support at the state level and become a template for other counties was because the BOCC officially endorsed and institutionalized it early on with an official resolution. This will be necessary for any county-wide comprehensive effort to focus on prevention. Additionally, a resolution could improve the Department's ability to coordinate with other governmental entities such as the City of Las Cruces and the El Paso County Department of Health and Environment.

A BOCC resolution for a prevention initiative ought to begin by recognizing several key facts. First, the resolution needs to start by acknowledging the county's statutory role in healthcare and public health, since that is necessary to explain why the county government should be taking an interest in these issues. Second, it must note that there are significant prevention efforts already going on all over the county by many organizations and individuals. This is critical both to demonstrate the feasibility of the effort and to acknowledge all the hard work currently being done every single day. Third, the resolution should acknowledge the challenges that health and healthcare pose to the county both in the present and in the future. This is important to explain the urgency for this new effort. Fourth, it should recognize that although it is never an easy solution, if done properly, prevention is an investment that both improves health outcomes and lowers costs. This is important as an explanation of why prevention is a path the county is taking. Fifth, the resolution ought to acknowledge Doña Ana County's unique status in New Mexico having such a comprehensive Health & Human Services Department and Health & Human Services Alliance, as well as the rapid changes in the health and healthcare status of Doña Ana County. Finally, the resolution should emphasize that

prevention efforts must not come at the expense of providing the current critical care that is the county's mandate and moral obligation.

In terms of what the BOCC should actually resolve that the county do, there are four key components. First, the resolution should commit the county, the Department, and the Alliance to taking prevention seriously and searching out every possible opportunity to increase prevention efforts in the county, starting with the priorities identified in the report of the *Juntos* forums. Second, the resolution should commit the Department and the Alliance to promoting greater use of partnerships in the design, implementation, and evaluation of prevention efforts. Third, the resolution should demand increased monitoring and measurement at both the programmatic and community-wide level, using the Healthy People/Healthy Gente/Healthy Border 2010 goals as a base (but including other priorities as they become identified). Finally, because the county Health & Human Services Department is relatively unusual in the state, the resolution should seek that, after Doña Ana County's prevention efforts are underway, the county's representatives in the state legislature should put forward a resolution at the state level declaring Doña Ana County a model for county-level prevention efforts statewide.

For a copy of the C*olonias Initiative* resolution, as well as the text of a sample resolution supporting this effort, please see Appendices D and E, respectively.

LOOKING AT THE LONG RUN

There is an incredible amount of activity related to health, healthcare, prevention, and wellness going on in Doña Ana County. However, that activity alone may not be enough to meet the rising health-related challenges in the county. Attempting to treat the current health needs of the community as a set of technical problems will probably not be sufficient in the long run. Instead, the county needs to look at its situation as an adaptive challenge that will require "experiments, new discoveries, and adjustments from numerous places in the…community."[82] At the moment, in the words of one stakeholder, "Doña Ana County only does it the Doña Ana County way."

The hope behind this paper was to get the Department, the Alliance, and the county to think about new ways to meet the current and coming challenges. The recommendations presented include just a few ways of going about this. Whether they are accepted or not, it is important to note that all the stakeholders interviewed both for this paper and in the preparation for the *Juntos* forums this summer were passionately committed to the health and healthcare of Doña Ana County. Although they sometimes (perhaps even often) disagreed on specific priorities and the means to achieve them, their overall ends are very much the same.

Googling "America's Healthiest County" returns zero hits.[83] Given the challenges of the county's border status, as well as the rural and low-income demographics of the population, it is certainly debatable whether that title is ever attainable for Doña Ana County. On the other hand, given the county's assets and the past evidence of its success when it comes together, there is no reason why Doña Ana County should not set a lofty and long-term goal of eventually laying claim to that title.

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APPENDICES

A. Partial List of Relevant Organizations, Partnerships, & Institutions

B. Doña Ana County Healthy Gente 2010/Healthy Border 2010 Report Card

C. Sample Page from Healthy Arizona 2010 Health Report Card 1999-2000

D. *Colonias Initiative* Board of County Commissioners Resolution

E. Sample Prevention Effort Board of County Commissioners Resolution

F. Description of *Colonias Initiative*

G. Research:

   a. Interviews Conducted

   b. County Health Department Plans Reviewed

   c. Bibliography

H. Acknowledgements

Appendix A: Partial List of Relevant Organizations, Partnerships & Institutions

ENTITY	BRIEF DESCRIPTION
Access to Care Committee	Partnership of organizations working on a joint Medical Information System for medical billing
Action for Youth	Community partnerships for youth development
AmeriCorps VISTAs	Federal program with many volunteers in the county
Ben Archer Health Clinics	Non-profit community health center with sites in northern and central Doña Ana County and in other counties
Border Epidemiology and Environmental Health Center	University center devoted to epidemiological strategies for improving the health of the region
City of Las Cruces and other municipalities	Municipal governments located in Doña Ana County
Community Action Agency of Southern New Mexico	Local non-profit social services corporation
Community Health Coalitions	Roughly a dozen coalitions of local residents working on neighborhood health issues and initiatives
Community Nurses Program	Joint state-county program that supports nurse visits to community resource centers throughout the county
Con Alma Foundation	Statewide non-profit devoted to health issues
Doña Ana Advocates for Children and Families	Non-profit devoted to increasing partnerships around local family well-being and stability issues
Dona Ana Branch Community College	NMSU-linked community college
Doña Ana Diabetes Action Coalition	Coalition devoted to diabetes prevention and awareness
Doña Ana County Immunization Coalition	Coalition dedicated to improving childhood vaccination rates in the county
Families & Youth, Incorporated	Social services provider for children and families
First Step Health Clinics	New pediatric and maternal/child health clinic
Health & Human Services Alliance	County-sponsored advisory body to the Department
Health & Human Services Department	County government department

Appendix A, Continued: Partial List of Relevant Organizations, Partnerships & Institutions

ENTITY	BRIEF DESCRIPTION
Healthcare Foundation of Southern New Mexico	Local philanthropic foundation dedicated to healthcare
La Clinica de Familia	Non-profit community health center with almost a dozen sites in southern and central Doña Ana County
La Piñon Sexual Assault Recovery Services	Service agency devoted to sexual assault issues
Memorial Medical Center	Privately leased hospital; largest in southern New Mexico
Mesilla Valley Economic Development Alliance	Local public-private economic development partnership
Mesilla Valley Hospital	Private psychiatric hospital
MountainView Regional Medical Center	Four-year old private hospital
New Mexico Dept of Health, Public Health Division, Region 5 Office	State government department located in Las Cruces
New Mexico State University (NMSU)	Land-grant university with many health-related programs
New Mexico WIC program	Federal-state nutrition program for mothers and children
Pasa del Norte Health Foundation	Regional non-profit devoted to health and wellness issues
Promotoras	Community health workers
Public Schools (Las Cruces, Gadsden, Hatch)	Three independent public school districts in the county
Southern Area Health Education Center	Local center for training and resources for health education
St. Luke's/Community of Hope	Non-profit center focusing on healthcare and other services for the homeless
Teen Collaborative	Local partnership devoted to reducing teen pregnancy
Teen Pregnancy Coalition	Statewide coalition devoted to reducing teen pregnancy
United Way	National non-profit with a local affiliate
US-Mexico Border Health Commission	Bi-national commission devoted border health issues
Walk Doña Ana	Public-private partnership devoted to increasing walking

Appendix B: Doña Ana County Healthy Gente 2010/Healthy Border 2010 Report Card

Summary of Dona Ana, NM baseline data for Healthy Gente/ Healthy Border 2010:

Objectives	2000					2010 Goals				
	US	US border States	NM	NM border Counties	Doña Ana County	US	US border States	NM	NM border Counties	Doña Ana County
1. **Reduce by 25% the population lacking access to primary care**	11.8	**	23.5	b	b	4.0	**	17.6	b	
2**. Reduce female breast cancer death rate by 20%** (per 100,000 women)	27.1	27.2	25.8	29.6	23.6	22.3	21.8	20.6	23.7	
3. **Reduce cervical cancer death rate by 30%** (per 100,000 women)	2.8	3.7	1.8	2.5	TFO	2.0	2.6	1.5	1.8	
4. **Reduce deaths due to diabetes by 10%** (per 100,000 inhabitants)	25.0	26.9	27.5	**35.5**	**36.0**	22.5	24.2	24.8	32.0	
5. **Reduce hospitalizations caused by diabetes by 25%** (per 10,000 inhabitants)	19.8	14.9	12.1	12.7	9.9	17.3	11.2	9.5	9.5	
6. **Reduce to zero the proportion of households w/o complete bathroom**	1.2	1.1	1.8	1.4	0.9	-	-	-	-	
7. **Reduce the number of hospital admissions for acute poisoning by 25%**	*	*	*	TFO	-	*	*	*	*	
8. **Reduce HIV+ incidence by 50%** (per 100,000 inhabitants)	a	8.4	7.3	**7.7**	**10.9**	*	4.2	3.7	3.8	
9. **Achieve 90% immunization coverage in children aged 19-35 months**	72.8	*	65.0	60.0	61.7	90.0	90.0	90.0	90.0	
10a. **Reduce incidence of Hepatitis A by 50%** (per 100,000 inhabitants)	4.9	11.0	3.8	**5.5**	**5.7**	4.5	5.5	1.9	2.7	
10b. **Reduce incidence of Hepatitis B by 50%** (per 100,000 inhabitants)	2.9	6.3	7.9	**7.7**	**8.6**	2.4	3.2	4.0	3.8	
11. **Reduce incidence of Tuberculosis by 50%** (per 100,000 inhabitants)	6.0	10.0	2.5	3.5	**3.4**	1.0	5.0	1.3	1.8	
12. **Reduce motor vehicle crash death rate by 25%** (per 100,000 inhabitants)	14.9	13.3	22.0	19.2	16.6	9.2	10.0	16.5	14.4	
13. **Reduce childhood death rate due to unintentional injuries by 30%** (per 100,000 children age 0-4)	14.0	14.7	19.0	17.1	-	*	10.3	9.7	12.0	
14. **Reduce infant mortality by 15%** (per 1,000 live births)	6.9	5.4	6.6	6.8	5.0	4.5	4.6	5.6	5.8	
15. **Reduce infant mortality from congenital abnormalities by 30%** (per 1,000 live births)	1.4	1.5	3.0	**2.3**	TFO	1.1	1.1	1.1	1.6	
16. **Increase percent of women beginning prenatal care in 1st trimester to 85%** (per 100 women)	83.0	73.2	65.3	64.6	68.0	90.0	85.0	85.0	85.0	
17. **Reduce pregnancy rate in adolescents 15-17 years old by 33 percent** (per 1,000 women 15-17 years of age)	48.7	41.8	39.1	**43.5**	**48.5**	43.0	28.0	43.9	29.1	

Appendix B, Cont'd: Doña Ana County Healthy Gente 2010/Healthy Border 2010 Report Card

Summary of Dona Ana, NM baseline data for Healthy Gente/ Healthy Border 2010:

Objectives	2000					2010 Goals				
	US	US border States	NM	NM border Counties	Doña Ana County	US	US border States	NM	NM border Counties	Doña Ana County
18. **Reduce suicide mortality rate by 15%** (per 100,000 inhabitants)	10.4	11.0	17.9	17.9	15.4	5.0	9.4	15.2	15.2	
19. **Increase percent of people using oral health care system annually to 75%**	**	**	**	**	**	56.0	**	**	**	
20. **Reduce asthma hospitalization rate by 40%** (per 10,000 inhabitants) (1998-2000 aggregated data)	12.1	8.7	9.4	7.8	6.9	25.0	5.2	5.6	4.7	
21. **Reduce the proportion of Adults who are obese by 15%**	20.1	c	19.3	b	b	15.0	c	16.4	b	
22. **Reduce the rate of alcohol related motor vehicle crash deaths by 50%** (per 100,000 inhabitants)	6.2	c	9.3	5.4	5.2	*	c	5.4	4.3	
23. **Increase to 89% the proportion of adolescents not using:**										
a. No alcohol in the past 30 days (2001 data, tracked every other year)	52.9	c	51.0	d	50.0	89.0	c	89.0	d	
b. No marijuana in the past 30 days (2001 data, tracked every other year)	76.1	c	73.1	d	80.0	89.0	c	89.0	d	
c. No cocaine use in the past 30 days (2001 data, tracked every other year)	95.8	c	95.4	d	94.0	89.0	c	89.0	d	
24. **Reduce by 33% the proportion of adults & adolescents using tobacco:**										
a. Adults (2000 data)	23.2	c	23.6	b	b	12.0	c	15.8	b	
b. Adolescents (2001 data, tracked every other year)	15.2	c	25.0	d	22.0	21.0	c	16.8	*	
25. **Reduce to zero the percent of the population residing in counties exceeding EPA air quality**	*	c	0.9	5.4	**7.4**	-	c	-	-	

* Data not available.

**Developmental Objective (Data not collected yet)

(a) data not collected at the national level for HIV in all States

(b) data not collected at the county level

(c) data not collected for Healthy Border

(d) data not available for all counties

Sources: National Center for Health Statistics (CDC), New Mexico Department of Health, New Mexico Health Policy Commission, EPA, YRBS, BRFSS and Healthy Border 2010, An Agenda for Improving Health on the US-Mexico Border (USMBHC).

TFO: Too Few Occurrences. Less than 5 events which can not be distributed to the public because of confidentiality issues.

For additional information please contact the BEC at 1-800-260-0509

Source: The Border Epidemiology and Environmental Health Center at NMSU

Appendix C: Sample Page from Healthy Arizona 2010 Health Report Card 1999-2000

PRIORITY AREAS	PROGRESS			
	Right Direction	Wrong Direction	No Change	Achieved Target
PHYSICAL ACTIVITY				
Reduce the proportion of adults who engage in no physical activity. 1999: 51.3% 2001: 21.9% 2000: 34.1% 2002: 22.6% BRFS[1]	✓			
NUTRITION				
Increase the proportion of persons aged 2 years and older who consume at least two daily servings of fruit and at least three daily servings of vegetables, with at least one-third being dark green or deep yellow vegetables. 1999: 30% 2001: 24.4% 2000: 36.9% 2002: 22.7% BRFS		✓		
TOBACCO USE				
Reduce tobacco use by youth in 6th – 8th grades. 2000: 11.4% 2003: 8.7% AZ YTS[2]	✓			
Reduce tobacco use by 20% by youth in 9th – 12th grades. 2000: 26.1% 2003: 17.7% AZ YTS				✓
Reduce tobacco use by adults 1999: 18.8% 2001: 21.5% 2000: 18.5% 2002: 23.4% BRFS		✓		
SUBSTANCE ABUSE				
Reduce mortality related to alcohol use. (Rate is per 100,000) 1999: 7.7 2001: 8.4 2000: 8.7 2002: 9.3 AZ Vital Statistics		✓		
Reduce mortality related to drug use. (Rate is per 100,000) 1999: 10.6 2001: 11.3 2000: 6.8 2002: 12.2 AZ Vital Statistics		✓		
RESPONSIBLE SEXUAL BEHAVIOR				
Reduce pregnancies among adolescent (15-17) females. (per 1000 pregnancies) 1999: 51.5 2001: 43.2 2000: 48.1 2002: 42.2 AZ Vital Statistics	✓			
MENTAL HEALTH				
Reduce deaths due to suicide. (Rate is per 100,000) 1999: 17 2001: 11.5 2000: 14.6 2002: 15.9 AZ Vital Statistics			✓	

[1] *Behavioral Risk Factor Survey*
[2] *Arizona Youth Tobacco Survey*

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Source: http://www.azdhs.gov/phs/healthyaz2010/healthyazreport_nov_03.pdf

Appendix D: *Colonias Initiative* Board of County Commissioners Resolution

12898

RESOLUTION NO. 2003-46

Resolution Designating and Recommending the Vado/Del Cerro Community as the Initial Model Colonia Community for the U.S. Dept. of Housing and Urban Development Model Colonia Initiative.

WHEREAS, the Board of County Commissioners of Dona Ana County is responsible for promoting and improving the Health, Safety, Welfare and Morals of the County's residents; and

WHEREAS, colonias are typically poorly developed communities that either lack or have substandard infrastructure and services to provide many of the basic necessities for human habitation, including natural gas service, adequate water service - including fire protection, wastewater service, roads, sidewalks, parks, street lighting, housing, health care, education and school bus service, and

WHEREAS, Dona Ana County currently has 37 designated colonias within its borders and many other communities that fit most of or all of the criteria and could be considered undesignated colonias, and

WHEREAS, there may be as many as 40,000 residents living in Dona Ana County's colonias, who are typically working poor and do not have the means to improve their communities, even though they often own property and pay Property and Gross Receipts taxes, and

WHEREAS, the Board of County Commissioners have designated Colonias Infrastructure Development as a County priority in its January 14, 2003 meeting, recognizing that a new approach is needed to address this very significant issue, and

WHEREAS, Dona Ana County has limited resources and is unable to address the colonias' needs in a timely manner, partly due to the fact that the per-capita income in New Mexico is fiftieth in the United States and the County's per-capita income is among the lowest in the State of New Mexico, with correspondingly low County operating revenue, considered on a per-capita basis, and

WHEREAS, The U.S. Dept. of Housing and Urban Development has advised the County of it's emerging program referred to as the Model Colonia Initiative, and is seeking a candidate as the initial site for the program implementation, which will master plan, then seek funding for the installation of the planned infrastructure, and

WHEREAS, the Board of County Commissioners is very desirous of having the Model Colonia Initiative begin in a County Colonia, such that the program may then be repeated in each additional colonia in the County to eventually bring all of the County's colonias up to an acceptable community standard,

WHEREAS, the Dept. of Housing and Urban Development (HUD) is implementing the Model Colonia Initiative and has expressed interest in a Dona Ana County colonia as the initial site for implementation, and

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WHEREAS, HUD has identified funding partners to assist with the Model Colonia initiative, which may include Federal and State partners such as USDA, FEMA, USGS, Homeland Security, EPA, DOE and the State administered CDBG program.

NOW, THEREFORE, the Board hereby resolves to designate and offer the Vado/Del Cerro community to HUD and its partners as the initial site for the Model Colonia Initiative, the community being a typical Border area colonia.

It is further resolved that the Board shall instruct County Management to dedicate County resources to support HUD and its partners in the successful implementation of the initial Model Colonia program, such that HUD will achieve the desired result and may utilize the results achieved as its Model program.

It is further resolved that the Board is prepared to enter into funding and/or fiscal agent agreements with HUD and its Federal and State partners to seek to obtain all necessary funding identified in the master plan developed for the Model Colonia, and to assist and/or implement the master plan as funding is made available.

ADOPTED this 8th day of April, 2003 in Las Cruces, Dona Ana County, State of New Mexico.

BOARD OF COUNTY COMMISSIONERS
DONA ANA COUNTY, NEW MEXICO

Paul B. Curry, Chair — Aye

Gilbert T. Apodaca, Vice Chair — Aye

Oscar Vasquez Butler, Member — Aye

Arturo C. Terrazas, Member — Aye

D. Kent Evans, Member — Aye

Attest:

J. Joe Martinez
Interim County Clerk

12898
APR 16 2003
9:10 A
414 1162-63

Appendix E: Sample Prevention Effort Board of County Commissioners Resolution

Whereas, Doña Ana County has a statutory obligation to promote the general health of its residents; and,

Whereas, there are already many organizations, institutions, and individuals dedicated to prevention efforts in the county; and,

Whereas, Doña Ana County faces significant health and healthcare challenges both in the present and in the future; and,

Whereas, if done properly, prevention is an investment that both improves health outcomes and lowers the costs of healthcare; and,

Whereas, Doña Ana County already has taken the initiative and put itself in a unique position in New Mexico by creating a comprehensive Health & Human Services Department and Health & Human Services Alliance; and,

Whereas, rapid changes are occurring in the health and healthcare status of Doña Ana County; and,

Whereas, there is room to increase the number and efficiency of prevention efforts without jeopardizing the current critical care that is the county's mandate and moral obligation.

Now, THEREFORE, be it resolved that the Board Of County Commissioners hereby commits the county, the Health and Human Services Department, and the Health and Human Services Alliance to focusing on prevention and seeking out every possible opportunity to increase prevention efforts in the county, starting with the priorities identified in the report of the Juntos Por Cambio Forums and the Healthy People 2010/Healthy Gente 2010 report card.

It is further resolved that the Department and the Alliance should seek to promote greater use of partnerships in the design, implementation, and evaluation of prevention efforts.

It is further resolved that the Department and the Alliance should make every effort to increase the monitoring and measurement of prevention efforts at both the programmatic and community-wide level, using the Healthy People/Healthy Gente/Healthy Border 2010 goals as a base (and including other priorities as they become identified).

It is further resolved that, because the county Health & Human Services Department is relatively distinctive in the state, after Doña Ana County's prevention efforts are underway, the county's representatives in the state legislature should be encouraged to put forward a resolution at the state level declaring Doña Ana County a model for county-level prevention efforts statewide.

Appendix F: Description of *Colonias Initiative* (Source: HHS Department)

Doña Ana County Colonias Initiative

Thirty-seven rural communities in Doña Ana County have been Federally designated as Colonias communities. These communities are located 62.5 to 150 miles from the US/Mexico Border and significantly lack basic infrastructure such as, public water/wastewater systems, proper flood control and drainage, paved and lighted roadways, adequate housing, transportation; and parks.

Based on the physical infrastructure rankings, county staff has developed the recipe for transformation and has prioritized necessary projects to bring the mentioned essentials to Colonia Communities.

On April 8th, 2003, the County Commission adopted a county resolution making Colonia issues a priority for the county.

On February 4th, 2004, the New Mexico Legislation proclaimed Colonias/Rural Communities a statewide priority.

In January 2004 the New Mexico Association of Counties adopted a state resolution making Colonia/Rural Communities a priority.

The staff began by analyzing and ranking essential physical infrastructure priorities that include the following:

- Whether or not a Colonia has adequate long range land use planning;
- Property plats/encroachment issues;
- Paved public roadways with curb and gutter;
- Proper drainage;
- Wastewater system infrastructure;
- Water system infrastructure;
- Panning & zoning codes enforcement.

The rankings provided an opportunity to prioritize critical projects identified by the Colonias. From there, the costs associated with critical projects were identified.

County staff and residents then presented the plan and priority projects to the state and federal legislature. The county and community residents have been successful in acquiring funding from state legislative representatives for many projects such as schools, water, wastewater, roads, multi-purpose centers, and parks. Legislators asked to submit requests for priority projects for FY 2005. State legislative priority projects for FY2006 have been submitted and are pending governor's approval. The Colonias Initiative is now implementing the $5M priority projects identified in the rankings and funded by FY 2005 legislative session. The Colonias Initiative is expected to take at least 15 to 20 years for a full successful implementation.

The Colonias Initiative is conducting outreach and education to community residents regarding the county services and support that various county departments provide. A Community Outreach Division has been established under the Health and Human Service Department to better address the residents' concerns and needs of services that address their quality of life, and health and safety issues of our rural communities.

In order to address the needs of Colonias residents in a comprehensive and effective manner, we have grouped our colonias into 3 regional clusters as follows:

Appendix F, Continued: Description of *Colonias Initiative,* p, 2

	Regional Colonias Clusters	
South Region (17)	**Central Region (11)**	**North Region (9)**
Anthony	Butterfield Park	
Berino	Cattleland Estates	Fort Seldon
Brazito	Doña Ana	Garfield
Chamberino	Fairacres	Leasburg
Chaparral	Hill	Milagro
Del Cerro	Moongate	Placitas
Joy Drive Subdivision	Mountain View	Radium Springs
La Mesa	Organ	Rincon
La Union	Picacho	Rodey
Las Palmeras	San Isidro	Salem
Mesquite	Winterhaven	
Montana Vista		
San Miguel		
San Pablo		
Sunland Park		
Tortugas		
Vado		

Critical Partners

•HUD Model Colonia Initiative	•NM Association of Counties
•NM Southern Delegation Legislators	•Border County Coalition
•NMED	•USDA
•NM Mortgage Finance Authority (NMMFA)	•BECC/NADBank
•NM Governors Office	•EPA
	•Department of Commerce
	•Private Foundations

The Colonias Initiative work has begun by implementing key initiatives, which will establish a strong foundation for development. These efforts include:

• County efforts between all departments have resulted in effective internal communication, which has provided cost savings, smoother project implementation for major infrastructure initiatives, and ultimately better quality of services to county residents.

• Drainage and flood control projects.

• Implementations of land use/mapped zoning in Colonias communities together with community residents to prevent mutated development once public infrastructure is put into communities.

• Implementation of a utility infrastructure plan to support planned growth and development.

• Providing a plan for emergency roadway access that will provide access to concentrated residential areas by emergency, school, and medical transportation.

The key physical infrastructure efforts identified above create better quality of life by an increased level of Health and Human Services, community resource centers, housing, parks, and recreation, and environmental and quality of life for the residents of our rural communities.

Plan Maestro—Building on Success

To date, the Colonia Initiative is being replicated in West Texas and Pima County Arizona. The Colonias Initiative is beginning to conduct extensive community outreach and education and building partnerships with community residents in addressing critical issues. The goal in the coming years is to strengthen our partnerships with state, federal, and private partners in support of our Colonias Initiative. The Colonias Initiative Workgroup looks forward to continue to update our partners as we move forward. Gracias!!!

Appendix G: Research:

INTERVIEWS CONDUCTED

Twenty-two interviews were conducted for this project. These included 16 interviews with key healthcare stakeholders in the county and six with academic or professional experts on the topics of public health, communications, psychology, health technology, and county government. All interviews were conducted either in person or by phone between December 2005 and April 2006.

For further information about the interviews conducted, please email Michael Ward at Michael_Ward@ksg06.harvard.edu.

Appendix G, Continued: Research

HEALTH DEPARTMENT STRATEGIC PLANS REVIEWED

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Although the end result of this project is not entirely what I had hoped for, that is entirely my responsibility. Whether or not the recommendations in this report are utilized, it is my hope that it will spur dialogue about the issues mentioned.

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